Opening Statement of
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Ranking Minority Member
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Hearing on Harm Reduction

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Mr. Chairman,

Thank you for holding today's hearing on harm reduction strategies for preventing illness and death among injecting drug users, their loved ones, and the broader population.

I am pleased that we are joined today by the Ranking Minority Member of the full Government Reform Committee, Mr. Waxman. Mr. Waxman's outstanding leadership on matters of public health is truly to be commended and I welcome his participation. I also welcome all of our witnesses. A number have traveled a considerable distance to share their perspectives on harm reduction and needle exchange and I appreciate their being with us today.

As you know, Mr. Chairman, injecting drug users are at elevated risk for infection with HIV and other blood-borne diseases due to the widespread use of contaminated injection equipment. In the United States, Russia, and most of Asia, including China, injection drug use is a major risk factor driving HIV infection rates in these highly populous, and in many cases, highly vulnerable societies. The enormous unmet need for drug prevention and treatment in these countries therefore is not just a concern from the standpoint of drug policy; it is a major factor in a global AIDS epidemic and it desperately requires effective interventions to halt the spread of HIV/AIDS among injecting drug users and the broader population.

Needle and syringe exchange has proved to be an effective intervention to prevent HIV infection among injection drug users. The science supporting the efficacy of needle exchange is thorough and consistent to the point that, today, there really is no serious scientific debate about whether needle exchange programs work as part of a comprehensive strategy to reduce HIV infection among high-risk injection users.

Indeed, numerous scientific reviews conducted in the United States and internationally confirm that syringe exchange programs, when implemented as part of a comprehensive HIV/AIDS prevention strategy, are effective in reducing the spread of HIV and other blood-borne illnesses. The most comprehensive of these was a review

conducted by the U.S. Department of Health and Human Services in 2000. Summarizing this report, then-Surgeon General David Satcher concluded:

> After reviewing all of the research to date, the senior scientists of the Department and I have unanimously agreed that there is conclusive evidence that syringe exchange programs, as part of a comprehensive HIV prevention strategy, are an effective public health intervention that reduces the transmission of HIV and does not encourage the use of illegal drugs.

Similarly, a 2004 review of the scientific literature by the World Health Organization found that, with regard to injecting drug users, "there is compelling evidence that increasing the availability and utilization of sterile injecting equipment reduces HIV infection substantially."

Last fall, at the request of Mr. Waxman and myself, the National Institutes of Health conducted a further review of the scientific literature to date and reported to us:

> the Federal Government has extensively examined the effectiveness of syringe exchange programs (SEPs) dating back to 1993, including reviews by the Government Accountability Office . . . The current scientific literature supports the conclusion that SEPs can be an effective component of a comprehensive community-based HIV prevention effort.
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> With unanimous consent, I'd like submit the NIH response for the record.

Not surprisingly, these comprehensive reviews validate research that has focused on needle exchange in my own city of Baltimore. For more than a decade, Dr. Peter Beilenson has overseen these efforts as Commissioner of the Baltimore City Health Department. I am pleased that he joins us today on the second witness panel and will discuss this research and his experience in detail. But suffice it to say, Mr. Chairman, the bottom line in Baltimore, as it has been elsewhere, is that needle exchange is a fundamental component of any comprehensive approach to reducing HIV infection.

Studies show that needle exchange programs like Baltimore City's reduce the number of contaminated needles in circulation, reduce the likelihood of HIV infection, bring the highest risk injecting drug users into contact with treatment resources and other critical social services, and do *not* increase drug use, the number of injecting drug users, or the volume of contaminated needles discarded in the streets.

In short, Mr. Chairman, these programs save lives, and that is why they have the unequivocal support of organizations like the American Medical Association, the U.S. Conference of Mayors, the National Academy of Sciences, the American Academy of Pediatrics, the International Red Cross-Red Crescent Society and UNICEF, to name a few.

Religious groups and denominations including the Episcopal Church, the Presbyterian Church, United Church of Christ, and the Progressive Jewish Alliance – again, just to name a few – also support making sterile needles available.

And states from coast to coast -- Maryland and California, included – recognize that needle exchange is not just effective; it is *cost*-effective and even *saves* taxpayer money given the avoided cost of treating would-be HIV/AIDS patients.

Those who state categorical arguments against harm reduction seem to overlook the fact that harm reduction is at the root of many mainstream measures to protect the public health in areas of activity, such as transportation, where engagement in the activity involves an inherent risk of injury or death. Speed limits, seat belt laws, and child safety seats, to cite a few familiar examples, all presuppose that the dangers inherent in vehicular transportation cannot be eliminated but that the number and severity of injuries can be reduced substantially for drivers, passengers, and innocent bystanders alike.

No one in this room disputes the fact that drug abuse is inherently unhealthy behavior. Needle exchange is a proven means of empowering injection users to take action to protect themselves, their sexual partners, and their children from the potentially fatal secondary risk of infection with HIV and other deadly or debilitating blood-borne diseases.

An injecting drug user who takes advantage of a needle exchange program is more likely to need treatment and more likely to obtain treatment than his or her counterpart who is outside the treatment system and not exchanging contaminated needles for sterile ones. Such a user is more likely to reduce the number of injections or to stop injecting altogether and is less likely to become infected or infect someone else with HIV. The proven benefits of participating in a treatment program, moreover, include reduced drug consumption, reduced risky health behavior, improved overall health, increased stability in housing and employment, reduced criminal conduct, and identification and treatment of co-occurring mental health problems.

Only a misinterpretation of the scientific literature could lead one to conclude that needle exchange programs are ineffective in reducing HIV or that they recruit new drug users or increase drug use. Strangely enough, however, we have seen this happen with a number of studies that support the efficacy of needle exchange.

For example, the Vancouver Injection Drug User Study is routinely cited by harm reduction opponents to support the erroneous view that needle exchange is ineffective and actually contributes to increases in drug use and HIV infection. In fact, as that study's authors have been compelled to point out, the Vancouver data confirms the program's effectiveness in reaching addicts most in need of treatment and most at risk of HIV infection. With unanimous consent, I'd like to submit letters from researchers to the National Institutes of Health refuting congressional misinterpretations of their research on needle exchange.

Mr. Chairman, today's hearing is likely to be one of numerous congressional hearings designed to scrutinize public health programs that fall under the broad umbrella of harm reduction. I hope we can help to demystify that term today and examine these programs from an objective public health point of view rather than through the often-distorting lens of ideology.

I also hope that as the public debate on harm reduction advances, we will be united in our motivation to preserve and protect the life and health of injecting drug users, their sexual partners, their children, and the broader community. If we do that, I believe we can build a political consensus of support for needle exchange that mirrors the scientific one, and many more lives may be saved as a result.

With that said, Mr. Chairman, I'd like to conclude my opening statement, but not without first saluting you for your leadership in introducing harm reduction legislation of your own that would make buprenorphine more readily available for the treatment of heroin addiction. I am proud to say that I was an original cosponsor of the Drug Addiction Treatment Expansion Act in the last Congress, and I look forward to continuing to work with you on that legislation and other important drug policy and public health matters.

I look forward to the testimony of all of our witnesses and yield back my time.

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